



# ***Birch Tree Communities, Inc.***

## **Admissions Info Sheet**

### **Admissions Department Contact**

Sarah Testa, LCSW, Admissions Director  
501-303-3109 office | 501-631-3794 fax

[sarah.testa@birchtree.org](mailto:sarah.testa@birchtree.org)

**Send referrals to [sarah.testa@birchtree.org](mailto:sarah.testa@birchtree.org) OR fax  
to 501-631-3794**

[Birchtree.org/admissions](http://Birchtree.org/admissions)

Birch Tree Communities, Inc. is a community-based program which provides housing and day treatment for adults (18+) diagnosed with a serious mental illness. We primarily see adults diagnosed with:

- Schizophrenia
- Bipolar Disorder
- Schizoaffective Disorder

Please call our Admissions Department with any questions regarding eligibility or to check the status of your application.

Court orders are not necessarily a guarantee of acceptance into our program. All applicants must be approved by our Admissions Committee which consists of our CEO, COO, CCO, Admissions Director, Director of Nursing, and our Medical Director.

Applicants must also provide income and asset verification in order to qualify for coverage and housing. All admissions must be assessed and tiered by one of the four Arkansas PASSEs.

**Birch Tree Communities, Inc. is not an emergency/crisis/acute care facility. If you or a loved one needs immediate help, please call 911 or visit your nearest emergency department for help.**

### **How do I get the process started and what do I need?**

**Make sure you have the following before pursuing the Admissions Process:**

1. Patient's Name
2. Social Security Number
3. Date of Birth
4. Proof of US Citizenship
5. Property ownership (this affects HUD eligibility)
6. Bank account info (this affects HUD eligibility)
7. Tiered, and assigned to a PASSE (Only clients assigned to Tier 2 or Tier 3 are eligible for admission.)

Once you have this information, send the initial Referral Form to the Admissions Department via fax or email.

Before the individual is presented to the Admissions Committee, we will also want to see a medication list, a psychiatric evaluation, and some form of treatment history/participation via progress notes

**Birch Tree Communities, Inc. cannot accommodate the treatment needs for applicants requiring:**

- Skilled Nursing Programs
- Waiver Services
- Sex Offender Registration





**Birch Tree Communities, Inc.**

Release of Information

I, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Client's Name Date of Birth SS #

Authorize Birch Tree Communities, Inc. to obtain Information from **The Social Security Administration, my Current and Previous Mental Health Providers (List here)**

\_\_\_\_\_

\_\_\_\_\_ and **family members (list name(s), Phone Number(s), and address(s))**

for the purpose of obtaining information including, but not limited to:

- Psychiatric evaluation
- Benefit information and eligibility
- MAR or Medication List
- Mental Health evaluation
- Treatment Plan(s)
- Presence/Participation in Treatment
- Progress Notes
- Physical/Vitals/Labs
- Aftercare/Discharge Summary
- Face Sheet/Demographic Information
- Psychotherapy Notes
- Verbal/Written Communication

YES  NO

\_\_\_\_\_  
Client's Printed Name Date of Birth SS#

\_\_\_\_\_  
Individual or Guardian Signature Date

\_\_\_\_\_  
Witness Signature if needed Date

**Transmission** Unless otherwise specified, Birch Tree Communities, Inc. reserves the right to disclose information as permitted by this authorization in any manner that is deemed to be appropriate and consistent with applicable law, including, but not limited to: verbally, in paper format, and/or electronically

**Sensitivity** I am aware that my records may contain sensitive information regarding my mental health, alcohol/substance use, and health diagnoses including HIV/AIDS, and other communicable diseases. I am aware this form is regulated by the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. The handling of my health information is also regulated by the Health Insurance Portability & Accountability Act, 45 CFR Parts 160 & 164.

**Re-Disclosure** This authorization does not give permission to re-disclose my information to other organizations without my express permission. I am aware that there are certain federal exceptions to redisclosure in which my information may be distributed for coverage, legitimate legal inquiries, or to address a genuine medical emergency

**Right to Decline** I am aware of my right to decline signing this form. I understand that my treatment will not be conditioned on my authorization unless medically necessary.

**Right to Revoke** I understand that I have the right to revoke my authorization in writing at any time by sending a written notification to Birch Tree Communities at the address listed below.